

**WELL BEING SYSTEMS, PLLC**  
**PATIENT – CLIENT INFORMATION**

LEGAL Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Today's Date \_\_\_\_\_  
(must match insurance card)

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
(If different)

Phone: Cell \_\_\_\_\_ Home \_\_\_\_\_  
Appt. reminders are text, voice and email

Email: \_\_\_\_\_

Person responsible for your account \_\_\_\_\_ relationship \_\_\_\_\_

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Ethnicity (circle): Hispanic \_\_\_\_\_ Non-Hispanic \_\_\_\_\_ Race: \_\_\_\_\_ I choose not to answer \_\_\_\_\_

Preferred language: \_\_\_\_\_

Relationship status:      Single                  Married                  Partnered

Name of Spouse/Partner (parents/guardian for minor) \_\_\_\_\_

Children & Ages (siblings for minor) \_\_\_\_\_

I GIVE PERMISSION FOR DR BURSTEIN TO RELEASE AND/OR RECEIVE MEDICAL OR FINANCIAL INFORMATION, WHICH MAY INCLUDE PROTECTED HEALTH INFORMATION, TO THE FOLLOWING PEOPLE, NOT INCLUDING HEALTH CARE PROVIDERS: (**OPTIONAL**)

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_ Patient Initials \_\_\_\_\_

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_ Patient Initials \_\_\_\_\_

Please note: Separate authorization form needed to release/receive information from health care providers. This form will be given upon request.

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Name of referring physician \_\_\_\_\_

In case of emergency notify \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

REFERRED BY - IF OTHER THAN YOUR DOCTOR \_\_\_\_\_

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Please explain why you are seeking help at this time:

\_\_\_\_\_

\_\_\_\_\_

Please explain how your problems are affecting your work and relationships, plus your general functioning:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

PG 2

Patient name \_\_\_\_\_ Date of Birth \_\_\_\_\_

On a 1 to 10 scale, with 1 = no distress and 10 = extreme distress, please rate your distress level now: \_\_\_\_\_

Please check any health problems you have or have had:

- |   |  |                                     |
|---|--|-------------------------------------|
| <input type="checkbox"/> lung               | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> arthritis  |
| <input type="checkbox"/> liver              | <input type="checkbox"/> diabetes            | <input type="checkbox"/> other pain |
| <input type="checkbox"/> kidney             | <input type="checkbox"/> seizures            | <input type="checkbox"/> cancer     |
| <input type="checkbox"/> stomach/intestinal | <input type="checkbox"/> head injury         |                                     |

Medicines you are allergic to:

\_\_\_\_\_

\_\_\_\_\_

Medicines you now take:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

How much and what kind of exercise you get:

\_\_\_\_\_

\_\_\_\_\_

Height \_\_\_\_\_

Weight \_\_\_\_\_

**SUBSTANCE USE**

Average amount Past 2 months

Most ever used

- |                    |       |       |
|--------------------|-------|-------|
| Coffee             | _____ | _____ |
| Cigarettes         | _____ | _____ |
| Alcohol            | _____ | _____ |
| Recreational Drugs | _____ | _____ |

Please rate your level of difficulty with these problems: 0 = none 1 = mild 2 = moderate 3 = severe

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Physical health         | <input type="checkbox"/> In-law problems                | <input type="checkbox"/> Using drugs            |
| <input type="checkbox"/> Chronic Pain            | <input type="checkbox"/> Job or school performance      | <input type="checkbox"/> Panic Attacks          |
| <input type="checkbox"/> Low mood                | <input type="checkbox"/> Friendships                    | <input type="checkbox"/> Phobias                |
| <input type="checkbox"/> Mood swings             | <input type="checkbox"/> Financial problems             | <input type="checkbox"/> Anxiety symptoms       |
| <input type="checkbox"/> Energy/motivation level | <input type="checkbox"/> Obsessions (unwanted thoughts) | <input type="checkbox"/> <i>sweating</i>        |
| <input type="checkbox"/> Memory                  | <input type="checkbox"/> Nightmares                     | <input type="checkbox"/> <i>short of breath</i> |
| <input type="checkbox"/> Concentration           | <input type="checkbox"/> Thoughts of hurting someone    | <input type="checkbox"/> <i>stomach upset</i>   |
| <input type="checkbox"/> Sleep                   | <input type="checkbox"/> Compulsions (unwanted actions) | <input type="checkbox"/> <i>dizziness</i>       |
| <input type="checkbox"/> Sexual functioning      | <input type="checkbox"/> Flashbacks                     | <input type="checkbox"/> <i>choking</i>         |
| <input type="checkbox"/> Suicidal thoughts       | <input type="checkbox"/> Paranoid thoughts              | <input type="checkbox"/> <i>racing heart</i>    |
| <input type="checkbox"/> Spirituality/religion   | <input type="checkbox"/> Domestic violence (verbal)     | <input type="checkbox"/> <i>weakness</i>        |
| <input type="checkbox"/> Marriage/relationship   | <input type="checkbox"/> Domestic violence (physical)   | <input type="checkbox"/> <i>dry mouth</i>       |
| <input type="checkbox"/> Family conflicts        | <input type="checkbox"/> Drinking alcohol               | <input type="checkbox"/> <i>feeling trapped</i> |
|  |   | <input type="checkbox"/> <i>panic</i>           |

For the following, please circle YES or NO and give details:

Have you had counseling or psychotherapy in the past? YES - NO \_\_\_\_\_

Have you ever taken medication for your emotional or mental health? YES - NO \_\_\_\_\_

Have you ever been hospitalized for psychiatric problems? YES - NO \_\_\_\_\_

Have you ever been arrested? YES - NO \_\_\_\_\_

Is there any mental/emotional trouble, alcoholism or drug use, or suicide in your family? YES - NO \_\_\_\_\_

Have you ever had any experiences that you would consider traumatic or abusive? YES - NO \_\_\_\_\_

Have you ever tried to kill yourself or hurt yourself in any way? YES - NO \_\_\_\_\_

Is there any danger these days that you might hurt yourself or someone else? YES - NO \_\_\_\_\_

Please describe your education:

\_\_\_\_\_

Please describe the family you grew up in including your parents and names and ages of your siblings:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please describe your marital or domestic partnership history. Include first names of current and past spouses, and your age at the time:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please describe your support system (family you are close to, friends you talk with, etc.):

\_\_\_\_\_  
\_\_\_\_\_

What is your current job and how do you like it?

\_\_\_\_\_  
\_\_\_\_\_

Please describe your religious affiliation and practice, if any:

\_\_\_\_\_  
\_\_\_\_\_

**SLEEP QUESTIONNAIRE –  
PLEASE COMPLETE IF YOU HAVE A SLEEP PROBLEM**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

What is the main problem with your sleep? \_\_\_\_\_

Are you a shift worker? **YES** or **NO** If so, what hours do you work? \_\_\_\_\_

On average, how many hours of sleep do you get in 24 hours? \_\_\_\_\_

All at once or with naps? \_\_\_\_\_ Is this enough? **YES** **NO** Or too much? **YES** **NO**

**INSOMNIA - POOR SLEEP QUALITY**

Do you have problems getting to sleep or staying asleep? **YES** **NO**

If so, is your main problem getting to sleep, or waking up too much, or both? \_\_\_\_\_

Do you tend to sleep at the wrong time; that is, are you an extreme night owl or morning lark? **YES** **NO**

If so, what is your best window of time for sleeping? \_\_\_\_\_

Do your legs or arms itch, burn, tingle or just feel “fidgety” when you are trying to sleep? **YES** **NO**

**EXCESSIVE SLEEP OR SLEEPINESS**

Are you often too sleepy when you need to be awake? **YES** **NO**

On your usual schedule in recent weeks or months, how likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? Even if you have not done some of these activities recently, try to answer according to how you think they might affect you. Choose the most appropriate number for each situation:

**0 = would never doze**      **1 = slight chance of dozing**    **2 = moderate chance**      **3 = high chance of dozing**

Sitting & reading	0	1	2	3	
Watching TV	0	1	2	3	
Sitting in a public place, like a waiting room	0	1	2	3	The Epworth Sleepiness Scale (John, M.W. (1993) Chest 103:30-36)
Riding in a car for 1 hour	0	1	2	3	
Lying down to rest	0	1	2	3	
Sitting & talking	0	1	2	3	
Sitting after lunch without alcohol	0	1	2	3	
Driving a care while stopped in traffic	0	1	2	3	

**Total Score** \_\_\_\_\_

If your score is 10 or higher, a sleep disorders consultation is recommended.

Other situations in which you fall asleep when you don't mean to? \_\_\_\_\_

Do you snore? **YES** **NO** Loudly enough to disturb others? **YES** **NO** Stop Breathing? **YES** **NO**

**SLEEP BEHAVIORS and OTHER PROBLEMS**

Do your legs or arms twitch or jerk during sleep? **YES** **NO** Whole body? **YES** **NO**

If either, do these twitches or jerks seem to interfere with your sleep? **YES** **NO**

Do you sleepwalk or act out dreams: **YES** **NO**


Do you fall out of bed or have unusual movements during sleep? **YES** **NO**

Have you ever injured yourself or someone else while asleep? **YES** **NO**

Do you have nightmares? **YES** **NO**

# MOOD DISORDER QUESTIONNAIRE

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

 Has there ever been a period of time when you were not your usual self and  
.....

You felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?  yes  no

You were so irritable that you shouted at people or started fights or arguments?  yes  no

You felt much more self confident than usual?  yes  no

You got much less sleep than usual and found you didn't miss it?  yes  no

You were much more talkative or spoke much faster than usual?  yes  no

Thoughts raced through your head or you couldn't slow down your mind?  yes  no

You were so easily distracted by things around you that you had trouble concentrating or staying on track?  yes  no

You had much more energy than usual?  yes  no

You were much more active or did many things more than usual?  yes  no


You were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?  yes  no


You were much more interested in sex than usual?  yes  no

You did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?  yes  no

Spending money got you or your family into trouble?  yes  no

.....

 **If you checked YES to more than one of the above, have several of these ever happened during the same period of time?**  yes  no

 **How much of a problem did any of these cause you – like being able to work; having family, money or legal troubles, getting into arguments or fights?**

- No Problem
- Minor Problem
- Moderate Problem
- Serious Problem